The prohibition on future contributions to section 401(h) accounts would be effective January 1, 1995 (or, if later, at the end of the current collective bargaining agreement, but in no event later than January 1, 1998).

The amendment to the welfare benefit fund rules requiring a ten-year funding period would be effective January 1, 1995. The other amendments to the welfare benefit fund rules would be effective with respect to additions to the reserve after enactment. No inference should be drawn as to whether these other amendments represent changes from current law.

SUBTITLE E - COORDINATION WITH COBRA CONTINUING CARE PROVISIONS
(H.R. 3600 and S. 1757 p. 1157)

Section 7501. Coordination with COBRA Continuing Care Provisions. Under current law, a group health plan that does not comply with the continuation coverage requirements under section 4980B of the Internal Revenue Code is subject to an excise tax of $100 per day for each violation. In general, a plan satisfies the continuation coverage requirements, which are commonly referred to as the "COBRA" requirements, if the plan continues to provide the opportunity for employees and their beneficiaries to purchase health coverage after a qualifying event. For this purpose, a qualifying event includes the death of the covered employee, termination of employment, certain changes in family or marital status, or entitlement to benefits under Medicare. COBRA coverage generally must continue for up to 18 months (or, in some cases, up to 36 months) after the qualifying event. However, COBRA coverage terminates if the employee or beneficiary is covered under Medicare or another group health plan before the end of the required time period.

The enactment of health care reform will make COBRA coverage unnecessary because health care coverage will be made available to all individuals. Therefore, the Health Security Act would repeal section 4980B of the Internal Revenue Code as of the earlier of January 1, 1998, or the first day of the first calendar year following the calendar year in which all States have in effect plans under which individuals are eligible for comprehensive health coverage described in the Health Security Act. For the transition period between enactment and full implementation of health reform, COBRA coverage would not be required to be offered, or to continue, once an individual becomes eligible for such comprehensive health coverage.

Except as described above, the provisions would be effective on the date of enactment.

SUBTITLE F - TAX TREATMENT OF ORGANIZATIONS PROVIDING HEALTH CARE SERVICES (H.R. 3600 and S. 1757 p. 1159)

Sections 7601, 7602, and 7603. Tax Treatment of Organizations Providing Health Care Services

(a) Nonprofit Health Care Organizations and Regional Alliances

Internal Revenue Code section 501(a) currently provides that certain organizations, including those described in Internal Revenue Code section 501(c), are generally exempt from income taxes. Among the organizations described in section 501(c) are organizations that are organized and operated exclusively for charitable purposes (section 501(c)(3)) and organizations not organized for profit but operated exclusively for the promotion of social welfare (section 501(c)(4)). Section 501(m) disqualifies an organization from exemption under section 501(c)(3) or (4) if it provides "commercial-type insurance" as a substantial part of its activities. The definition of commercial-type insurance does not include incidental health insurance of a type customarily provided by a health maintenance organization (HMO).

Revenue Ruling 69-545 holds that a nonprofit hospital is a tax-exempt charitable organization if it promotes the health of a class of persons broad enough to benefit the community and operates to serve a public, rather than a private, interest.

An HMO that provides health services predominantly at its own facilities through the use of its own staff may qualify as a tax-exempt charitable organization under the same standards that govern nonprofit hospitals. *Sound Health Association v. Commissioner*, 71 T.C. 158 (1978). By contrast, an HMO that does not provide health care services itself may be denied exemption as a charitable organization under section 501(c)(3). *Geisinger Health Plan v. Commissioner*, 985 F.2d 1210 (3d Cir. 1993). A non-provider HMO may qualify for exemption, however, as a social welfare organization described in section 501(c)(4).

Private foundations are subject to certain excise taxes. In general, private foundations include tax-exempt charitable organizations other than churches, schools, hospitals, organizations that normally receive more than one third of their financial support from the public, and "support" organizations that are organized and operated exclusively for the benefit of an organization that is not a private foundation.

Present law provides no rule that applies specifically to regional alliances.

A nonprofit health care provider should not qualify for tax exemption unless it provides services that are beneficial to the community. Therefore, the Health Security Act

would adopt new rules to provide further assurance that nonprofit health care providers are responsive to the needs of their communities.

The Health Security Act would provide a new standard that nonprofit health care providers must meet to qualify as tax-exempt charitable organizations. A provider meets this standard if, at least annually, and with the participation of community representatives, it assesses the health care needs of its community and develops a plan to meet those needs. This standard would apply in addition to the community benefit standard of current law.

The Act would also clarify the tax treatment of nonprofit HMOs. First, consistent with the *Sound Health Association* and *Geisinger Health Plan* cases, the Act would clarify that an HMO can qualify for exemption as a charitable organization described in section 501(c)(3) only if it provides health care services to its members at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of the HMO. In addition, the HMO must also meet the community plan and benefit standards.

Second, for HMOs qualifying for exemption under sections 501(c)(3) or 501(c)(4), the Health Security Act would provide rules regarding the treatment of certain types of insurance provided by an HMO as commercial-type insurance under section 501(m). Under these rules, "point-of-service" benefits relating to care provided outside the HMO's provider network are treated as commercial-type insurance. However, tax-exempt status should not be jeopardized unless point-of-service benefits comprise a substantial portion of the HMO's activities. This is likely to occur only if the HMO's network of providers is inadequate or unresponsive to the needs of the members. In that case, the justification for continued tax exemption would be questionable.

Insurance would not be treated as commercial-type insurance if it relates to (i) care provided by the HMO to its members at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of the HMO, (ii) primary care provided by a health care professional to a member of the HMO on a basis under which the amount paid to the professional does not vary with the amount of care provided to the member, (iii) services other than primary care provided within the HMO's provider network, or (iv) emergency care provided to a member of the HMO outside the member's area of residence. These rules codify the Internal Revenue Service's current interpretation of section 501(m). *See* General Counsel Memorandum 39829 (Aug. 30, 1990).

Many hospitals are part of reorganized systems that are under the control of a parent organization that serves essentially as a holding company for the system. To clarify that these parent organizations are not private foundations, the Health Security Act would provide a new exception from the definition of that term. The new exception would apply to parent organizations that are organized and operated for the benefit of a hospital (or other organization described in Internal Revenue Code section 170(b)(1)(A)(iii)) that is directly or indirectly controlled by the parent organization.

The Act would add a new paragraph to section 501(c) to specifically exempt regional alliances from tax. The Act would also provide that regional alliances are treated as not described in any other paragraph of section 501(c).

The proposal regarding nonprofit health care providers would take effect on January 1, 1995. The proposals regarding insurance provided by HMOs and the treatment of parent organizations would take effect on the date of enactment of the Health Security Act. The proposal regarding regional alliances would apply to taxable years beginning after the date of enactment.

(b) Taxable Health Care Organizations

Under current law, it is uncertain whether an HMO should be taxed as an insurance company or as a regular corporation. If taxed as an insurance company, the HMO is entitled to deduct an estimate of the liability for services rendered to members prior to the end of the tax year but for which a claim has not been received by the HMO. These are referred to as incurred-but-not-reported (IBNR) claims. Revenue Ruling 68-27 held that an HMO that provides medical care through its own provider-employees was not an insurance company. However, the issue regarding deductibility of IBNR claims is less important for this type of HMO because generally all services that have been rendered by the HMO's provider-employees prior to the end of the tax year would be known and no IBNR liability would exist. It is unlikely that regular corporations can sustain a tax deduction for IBNR claims due to the Supreme Court's decision in *General Dynamics*.

Treasury Regulations provide that in determining whether a contract constitutes an insurance contract for medical care, it is irrelevant whether the benefits under the contract are payable in cash or services.

There is little distinction between the operation of most HMOs and insurance companies. Whether a for-profit HMO capitates its providers or reimburses on a fee-for-service basis, the HMO assumes a risk when it agrees to provide medical service to its members in exchange for a fixed premium. It is irrelevant for purposes of determining the insurance status of the contract that medical care benefits are delivered to members of the HMO in the form of services rather than cash. Accordingly, the HMO can be viewed as an insurance company. Taxing HMOs as insurance companies matches income and expense. Premiums would be recognized over the period that coverage for medical services is provided. Corresponding liabilities would be accrued and deducted to the extent the HMO is liable to provide services. Accordingly, a deduction would be allowed for accrued IBNR claims at year end, a reserve for unearned premiums would be permitted (subject to the 20-percent reduction under current law), and 15 percent of certain tax-advantaged income would be taxable.

Under the Health Security Act, for-profit HMOs and similar prepaid health care

service entities would be taxed as insurance companies other than life insurance companies under the provisions of Subchapter L of the Internal Revenue Code. Also, any organization, other than a life insurer or exempt organization, would be taxed as a property/casualty insurance company if its primary and predominant business activity is the issuance and/or administration of accident and health insurance contracts or reinsurance of such contracts, but only if the issuance or reinsurance of such contracts represents a material business activity of the organization. Cost-plus contracts of the nature typically issued by Blue Cross/Blue Shield organizations would be treated as accident and health insurance contracts for this purpose. The proposal would replace the current section 833 (dealing with Blue Cross/Blue Shield organizations).

The proposal would be effective for taxable years beginning after December 31, 1996. Any accounting method changes required by the proposal for taxable entities would be made in the first taxable year beginning after December 31, 1996.

(c) Blue Cross/Blue Shield Organizations

Under current law, Blue Cross/Blue Shield organizations (Blues) are generally taxed as property/casualty insurance companies, with exceptions. The Blues are entitled to a special income tax deduction, calculated as the difference between 25 percent of their health claims (including claims expenses) and their adjusted surplus. This special deduction is not permitted as a deduction in determining alternative minimum taxable income. The Blues are also exempt from a rule that requires other property/casualty companies to include 20 percent of the change in their unearned premium reserves in taxable income.

The special deduction was provided in recognition of the fact that the Blues write health insurance policies for individuals and small groups for a reasonable premium, without excluding persons with pre-existing medical conditions. The Blues generally charge community-rated premiums.

The Health Security Act would prevent any insurance company from denying enrollment to an applicant because of health, employment, or financial status. It would also prevent insurance companies from charging higher premiums to persons more likely to incur higher medical costs because of pre-existing conditions, age, or other factors related to risk. The Act would effectively require all plans receiving premiums through health alliances to charge community-rated premiums for the comprehensive benefits package. Accordingly, a subsidy to Blue Cross/Blue Shield companies would no longer be needed to make community-rated premiums available to the public. However, uniform tax rules for insurance companies selling community-rated policies would be needed to provide a framework for effective market competition between the Blues and other health insurers.

The Tax Reform Act of 1986, which revoked the Blues' tax-exempt status, required other insurers to include 20 percent of the change in their unearned premium reserves in taxable income to provide better matching of premium income and policy acquisition

expenses. The companies were also required to include 20 percent of their existing December 31, 1986 unearned premium reserves in taxable income ratably over a six-year period, starting in 1987. (No modification to the amount of income inclusion was allowed for companies, such as mutual property/casualty insurers, that had been exempt from tax at some time in their history.) The Blues were originally exempted from the 20-percent rule because any mismatching of currently deductible premium acquisition expenses and deferred premiums had no significant tax impact since the Blues were exempt from tax. The exemption from the 20-percent rule was also designed to ease the transition from tax-exempt to taxable status. Now that the Blues have been taxable for several years, continued exemption from the 20-percent rule is unnecessary, regardless of whether the 20-percent rule reflects the actual acquisition expenses of health insurers. The elimination of the exemption from the 20-percent rule should follow the same transition rules that were provided in the 1986 Act.

After enactment of the Health Security Act, it is anticipated that Blues organizations would remain taxable as insurance companies other than life insurance companies under the provisions of Subchapter L of the Internal Revenue Code. However, the special deduction would be generally repealed for regular tax purposes (as it currently is for alternative minimum tax purposes). A moderate phase-out of the special deduction would be available for Blues that meet special eligibility criteria in both 1995 and 1996. The eligibility standards are identical to the standards under existing section 833(c)(3) for organizations desiring to qualify as Blues. The allowable deduction for Blues that satisfy the standards would be 67 percent of the current special deduction in 1997, 33 percent in 1998, and nothing thereafter.

Blues would be required to include 20 percent of the change in their unearned premium reserves in taxable income. Under a transition rule, 20 percent of any existing unearned premium reserve balance would be included in taxable income ratably over a six-year period.

The proposal would generally become effective for taxable years beginning after December 31, 1996.

SUBTITLE G - TAX TREATMENT OF LONG-TERM CARE INSURANCE AND SERVICES
(H.R. 3600 and S. 1757 p. 1171)

Section 7701. Qualified Long-Term Care Services Treated as Medical Care. Internal Revenue Code section 213 currently provides a deduction for medical care expenses subject to a floor of 7.5 percent of adjusted gross income. Expenses for medical care include expenses for "the diagnosis, cure, mitigation, treatment, or prevention of disease...[and] those paid for the purpose of affecting any structure or function of the body or for transportation primarily for and essential to medical care." Under regulations, medical care expenses are "confined strictly to expenses incurred for the prevention or alleviation of a physical or mental defect or illness," and do not include expenditures that are "merely beneficial to the general health of an individual." The authorities generally indicate that the cost of personal services, including custodial care, is a medical expense if there is a direct connection between the service and a recognized, specific medical condition. Old age is not a sufficiently specific medical condition for this purpose.

The authorities also indicate that services must be performed directly for the individual. By contrast, services such as housekeeping, cooking, gardening, etc. which are not performed directly for an individual are not considered directly related to a specific medical condition. Where services qualifying as medical care are provided in addition to services not qualifying as medical care, an allocation is generally required.

Regulations provide that the entire amount of an expense may be treated as medical expense if the expense is incurred primarily to provide medical care. Under this rule, the entire cost of services provided in a nursing home or similar institution may be a medical expense if the principal purpose for the individual's presence is the availability of medical care at the institution.

The Health Security Act would provide necessary guidance in establishing the deductibility of long-term care expenses incurred by an incapacitated individual. The definition of medical care under Internal Revenue Code section 213 would be expanded to include qualified long-term care services. Services performed for an incapacitated individual would be treated as deductible medical expenses subject to the 7.5-percent floor. An incapacitated individual is a person who is unable to perform without substantial assistance at least two activities of daily living or suffers from severe cognitive impairment. No inference should be drawn as to whether this amendment represents a change from current law.

Medical care service expenses incurred by an individual who is not incapacitated under this definition would be deductible, as provided under current law.

The provision would apply to taxable years beginning after December 31, 1995.

Section 7702. Treatment of Long-Term Care Insurance. Generally, the treatment under current law of benefits provided under a long-term care insurance policy is unclear. To the extent that long-term care is not treated as medical care, employer-provided long-term care coverage would not be excludable accident or health coverage under Internal Revenue Code section 106, and the value of the coverage would be taxable to the employee. Generally, benefits paid under a long-term care plan or policy would not be treated as amounts received through accident and health insurance on an excludable basis under Internal Revenue Code section 104 or 105, unless the amounts received for long-term care represent reimbursement for medical care.

Favorable tax treatment would be provided by the Health Security Act to encourage the purchase of qualified private long-term care insurance to assist with the financial protection of an aging population. Following the design of the health reform plan, which provides for a comprehensive benefit package, the Health Security Act would establish favorable tax treatment for a qualified long-term care insurance policy. Supplemental long-term care insurance policies could be purchased but would not receive the same tax benefits as a qualified policy.

Under the Act, premiums paid for a qualified long-term care policy would be deductible as a trade or business expense or as an itemized deduction subject to the 7.5-percent-of-adjusted-gross-income floor; the value of employer-provided coverage under the policy would not be taxable to an employee; and benefits under the policy would not be taxable to the recipient. However, funding the purchase of the policy on a tax-favored basis through a cafeteria plan would not be permitted.

A qualified long-term care insurance policy would be required to:

(a) satisfy certain regulatory standards set forth in the Health Security Act;

(b) condition eligibility for benefits on being unable to perform at least two activities of daily living or on suffering severe cognitive impairment;

(c) not allow immediate prefunding or cash values; and

(d) limit benefits to $150 per day (indexed for medical inflation) without regard to actual incurred long-term care expenses.

Any long-term care coverage provided by rider on a life insurance contract would be treated as a separate contract. The addition of a long-term care insurance rider would not be treated as a modification or material change of the contract for purposes of Internal Revenue Code sections 7702 and 7702A.

The provision would apply to policies issued after December 31, 1995. A transition rule would permit existing long-term care insurance policies to be exchanged for qualified

long-term care insurance policies without recognition of gain or loss.

Sections 7703 and 7704. Tax Treatment of Accelerated Death Benefits
(a) Accelerated Death Benefits Under Life Insurance Contracts

Payments made under a life insurance contract other than by reason of an insured's death are generally taxable under current law. However, the tax treatment of payments made under certain circumstances is not entirely clear.

Recognizing the benefits to society of life insurance protection, the tax system encourages the purchase of life insurance by allowing tax-free "inside buildup" and the payment of tax-free benefits upon the insured's death. Other tax provisions limit the extent to which the tax-favored nature of the insurance contract can be abused as a tax-favored investment vehicle.

Terminally ill individuals face varied needs in their last months of life. Gaining access during these months to a portion of the death benefit under their life insurance contract can ease some of the financial burden of the terminal illness. However, there is also a need to balance the financial protection of the beneficiaries under the life insurance contracts (which is the primary purpose of life insurance) against the needs of the terminally ill.

While the tax system supports the purchase of life insurance as a means of providing financial protection for the insured's beneficiaries, the tax system should also support the purchase of an accelerated death benefit rider on a life insurance contract as a means of providing financial protection for the insured who becomes terminally ill. However, the system should not permit abuse of the tax-favored nature of life insurance by allowing unlimited access to death benefits prior to death. The insurance feature would be undermined if the insurance contract were to become a generous tax-favored investment vehicle. Recognizing this potential for abuse, the accelerated payment of death benefits should be permitted on a tax-free basis only if the death of the insured is imminent. The insurance element of the contract would thus not be undermined.

The Health Security Act would provide insurers with standards needed to design and market insurance contracts that provide for payment of benefits prior to an insured's death without subjecting policyholders to taxation on the additions to cash value within the life insurance contract. In recognition of the needs of individuals who become terminally ill, the proposal would allow an accelerated death benefit received by an individual on the life of an insured who is expected, due to terminal illness, to die within 12 months to be excluded from taxable income as a payment by reason of death. No inference should be drawn as to whether this amendment represents a change from current law.

The provision would apply to taxable years beginning after December 31, 1993.

(b) Companies Issuing Qualified Accelerated Death Benefit Riders

Under current law, insurance contracts have been developed that provide for payment of death benefits under a life insurance policy, as a result of terminal illness, prior to an insured's death. Generally, the accelerated death benefit is equal to all or a portion of the death benefit, discounted for the remaining life expectancy (generally 12 months or less) of a terminally ill individual. Internal Revenue Code section 7702 defines a life insurance contract as any contract that is a life insurance contract under applicable law, but only if the contract either (1) meets the cash value accumulation test of section 7702(b), or (2) meets the guideline premium requirements of 7702(c) and falls within the cash value corridor of section 7702(d). For purposes of section 7702, the accelerated death benefit could be viewed as an amount paid upon surrender of a contract and accordingly would be included in the cash surrender value of the contract. The impact of this characterization would be to disqualify as life insurance under section 7702 contracts providing accelerated death benefits.

As discussed above, it is desirable that the tax system support the purchase of an accelerated death benefit rider on a life insurance contract as a means of providing financial protection for the insured who becomes terminally ill. Accordingly, the proposal allows an accelerated death benefit rider to be sold in conjunction with a life insurance contract without causing disqualification of the contract as a life insurance contract. This protects the policyholder from taxation on the inside buildup in the life insurance contract.

The Health Security Act would expand the definition of a life insurance contract to include a qualified accelerated death benefit rider on the contract and would treat the rider as a qualified additional benefit under section 7702(f)(5)(A). Also, the addition of an accelerated death benefit rider to a life insurance contract would not be treated as a modification or material change of the contract for purposes of sections 7702 and 7702A. No inference should be drawn as to whether this amendment represents a change from current law.

The provision would apply to contracts issued after December 31, 1993.

SUBTITLE H - TAX INCENTIVES FOR HEALTH SERVICES PROVIDERS (H.R. 3600 and S. 1757 p. 1192)

Sections 7801 and 7802. Tax Incentives for Health Services Providers. Since the early 1970s, the problems of shortages of health care professionals in certain geographic areas have been the target of the National Health Service Corps (NHSC) program. Pursuant to that program, participating health care professionals who agree to practice in "health professional shortage areas" (HPSAs) may receive scholarships or amounts that are used for the repayment of educational loans.

There continue to be significant shortages of health care professionals in a number of urban and rural areas. Tax incentives would encourage health care professionals to locate in underserved areas and thereby help alleviate these shortages. The current NHSC program has not been sufficient to eliminate these shortages.

The Health Security Act would provide two tax incentives: (i) a nonrefundable credit for certain primary health services providers (section 7801), and (ii) increased expensing under section 179 for certain medical equipment (section 7802).

(a) Non-refundable Credit for Certain Primary Health Services Providers

This proposal would provide a $1,000 per month tax credit for physicians (and a $500 per month credit for physician assistants, nurse practitioners, and certified nurse-midwives) who provide primary health services on a full-time basis in HPSAs. To be eligible for the credit, the individual must first apply for certification, and be certified, by the Department of Health and Human Services in a manner similar to that currently in effect under the existing NHSC program. An individual would be eligible for the credit for up to a maximum of 60 months. Previously claimed credits would be subject to complete or partial recapture if the individual works in the HPSA for less than 60 months. The credit would not be available to health care professionals who begin work in the HPSA before 1995. In an effort to coordinate this tax incentive with NHSC programs, individuals who have previously participated in NHSC programs would not be eligible for the credit.

(b) Increased Expensing of Medical Equipment

Under this proposal, an additional $10,000 of expensing under Internal Revenue Code section 179 would be available for certain medical equipment owned and used by a physician in a HPSA in the active conduct of the physician's full-time trade or business of providing primary health services in the HPSA. As the Omnibus Budget Reconciliation Act of 1993 increased the general section 179 annual limit from $10,000 to $17,500, the combined limit would be increased to $27,500. This expanded level of expensing would apply to equipment used in the screening, monitoring, observation, diagnosis, or treatment of patients in a laboratory, medical, or hospital environment.

The credit would generally be effective for taxable years beginning after December 31, 1994. The increased expensing would be effective for medical equipment placed in service after December 31, 1994.

SUBTITLE I - MISCELLANEOUS PROVISIONS
(H.R. 3600 and S. 1757 p. 1199)

Section 7901. Credit for Cost of Personal Assistance Services Required by Employed Individuals. The Internal Revenue Code currently provides tax credits to assist certain categories of workers and disabled taxpayers. For example, the earned income tax credit is available to low-income workers. The dependent care credit is available to taxpayers who incur household and dependent care expenses in order to be able to work. The elderly and those who are totally and permanently disabled are entitled to a credit regardless of whether they are employed.

Individuals with disabilities who are capable of working face a number of special challenges in the daily activities that are associated with gainful employment. The incentives provided to these individuals will assist them in their efforts to become, and remain, part of the work force.

A nonrefundable tax credit would be made available to individuals who work and who, by reason of a medically determinable physical impairment that has lasted (or can be expected to last) for at least 12 months, would be unable to engage in substantial gainful activity without personal assistance services. The amount of the credit would be based on (i) the level of specified personal assistance expenses, (ii) the individual's earned income, and (iii) the individual's (and his or her spouse's) adjusted gross income. For taxpayers with adjusted gross income of less than $50,000, the credit would be equal to 50 percent of up to $15,000 in personal assistance expenses (or 50 percent of earned income, if the individual's personal assistance expenses exceed his or her earned income) -- for a maximum credit of $7,500. The rate of the credit, and accordingly the maximum possible credit, would be phased down for taxpayers with adjusted gross income between $50,000 and $70,000 (with no credit available for taxpayers with adjusted gross income over $70,000).

The credit would be effective for taxable years beginning after December 31, 1995.

Section 7902. Denial of Tax-Exempt Status for Borrowings of Health Care-Related Entities. State and local governments generally may issue tax-exempt bonds to finance their activities. Except in the case of certain qualified bonds, however, under current law, the interest on private activity bonds is not tax-exempt. Private activity bonds include bonds issued as part of an issue if: (1) more than 10 percent of the proceeds are to be used for any private business use (the "private business use test"), and (2) the principal of, or interest on, more than 10 percent of the issue is either secured by property used in a private business use (or payments in respect of such property) or to be derived from payments in respect of property used for a private business use (the "private security or payment test"). The Internal Revenue Code defines qualified bonds to include certain bonds for section 501(c)(3) organizations ("qualified 501(c)(3) bonds").

Generally, the Federal tax laws are designed to limit the ability of State and local governments to issue tax-exempt bonds to be used for other than traditional governmental purposes. Health care alliances and State guaranty funds described in section 1204 of the Health Security Act would perform functions that have traditionally been performed by the private sector. Regardless of who the operator is, each alliance would be organized for the benefit of, and would be financially supported by, the individual members of that alliance. Similarly, State guaranty funds would be operated for the benefit of those covered by the fund. It is inappropriate to provide the indirect Federal subsidy implicit in tax-exempt bonds to the individuals who benefit from the alliances and guaranty funds.

Where appropriate, the Health Security Act would provide more efficient, direct subsidies to individuals in need of Federal assistance in obtaining health insurance, and would prevent State and local governments from substituting tax-exempt debt for taxable debt in these situations. If alliances and guaranty funds were allowed to benefit from tax-exempt financing, there would be a significant revenue loss to the Federal government and an increase in the interest rates that State and local governments are required to pay to finance their activities.

The Act would provide that the use of bond proceeds by a health care alliance or State guaranty fund would be private business use. Therefore, issues of bonds more than 10 percent of the proceeds of which are used to finance the activities of health care alliances or State guaranty funds would be private activity bonds the interest on which would not be tax-exempt (unless the issue failed to meet the private security or payment test).

The amendment would apply to obligations issued after the date of enactment.

Section 7903. Disclosure of Return Information for Administration of Certain Programs Under the Health Security Act. The Internal Revenue Code currently prohibits disclosure of tax returns and return information, except to the extent specifically authorized by Code section 6103. Unauthorized disclosure is a felony punishable by a fine not exceeding $5,000 or imprisonment of not more than five years, or both (Code section 7213). An action for civil damages also may be brought for unauthorized disclosure (Code section 7431). In general, no tax information may be furnished by the Internal Revenue Service to another agency unless the other agency establishes procedures satisfactory to the Internal Revenue Service for safeguarding the tax information it receives (Code section 6103(p)).

The Health Security Act provides for several assistance programs, such as premium discounts for low-income individuals, that would be income-based. The States would verify income information provided by individuals to ensure that they qualify to receive the assistance. Federal tax returns provide the only comprehensive source of information for such verification.

The Act would permit disclosure to Federal and State agencies of certain return

information with respect to assistance provided under the Act. The Act would extend the current-law restrictions on unauthorized disclosure to Federal and State agencies and their employees. Those employees would not be permitted to redisclose tax information to any third party.

The amendment would be effective on the date of enactment.

TITLE VIII - HEALTH AND HEALTH-RELATED PROGRAMS OF THE FEDERAL GOVERNMENT

SUBTITLE A - MILITARY HEALTH CARE REFORM (H.R. 3600 and S. 1757 p. 1207)

Section 8001. Uniformed Services Health Plans.

(a) Chapter 55 of title 10, United States Code, is amended by inserting section 1073a after section 1073. Section 1073a provides:

(a) The Secretary of Defense may establish one or more Uniformed Services Health Plans. The Secretary of Defense must issue regulations to carry out this section. Uniformed Services Health Plans must conform, to the maximum extent practicable, to other requirements for health plans under the Health Security Act.

(b) A Uniformed Services Health Plan may rely upon the use of facilities of the uniformed services for the provision of health care services, supplemented by the use of civilian health care providers or health plans under agreements entered into by the Secretary of Defense. An agreement with a civilian health care provider or a health plan may be entered into without regard to provisions of law requiring the use of competitive procedures. An agreement with a health plan may provide for the sharing of resources with the health plan that is a party to the agreement.

(c) A Uniformed Services Health Plan must provide the items and services in the comprehensive benefit package to persons enrolled in the plan. In addition, a Uniformed Services Health Plan must guarantee to those members of the uniformed services on active duty for a period of more than 30 days as of December 31, 1994 or any person who is a covered beneficiary as of that date who enroll in a Uniformed Services Health Plan those health care services that the person would be entitled to receive under chapter 55 in the absence of this section.

(d) In carrying out its responsibilities under the Health Security Act, a state (or state-established entity) may not impose any standard or requirement or deny certification to a Uniformed Services Health Plan because of a conflict with this section or any regulation prescribed pursuant to this section or other Federal law regarding the operation of this section.

(e) Except as authorized by an administering Secretary, each member of a uniformed service on active duty for a period of more than 30 days must enroll in a Uniformed Services Health Plan available to the member. After enrolling active duty members, Uniformed Services Health Plans may enroll first spouses and children of members of the uniformed services who are on active duty for a period of more than 30 days, and then individuals described in subsection 1086 of title 10. For all enrollees, participation in a Uniformed Services Health Plan is the exclusive source of

health care services available to the member or person under chapter 55.

(f) If person is eligible to enroll in a Uniformed Services Health Plan but does not enroll, the person is not entitled or eligible for health care services in facilities of the uniformed services or pursuant to a contract entered into under chapter 55. However, the person may receive a premium payment from the Secretary of Defense as described in paragraph (h).

A person who is eligible to enroll in a Uniformed Services Health Plan but enrolls in another health plan may receive the items and services in the comprehensive benefit package in a facility of the uniformed services only if:

(1) the Secretary of Defense authorizes the provision of a particular item or service in the package to the person;

(2) the Secretary determines that the provision of the item or service will not interfere with the provision of health care services to members of the uniformed services or persons enrolled in a Uniformed Health Services Plan; and

(3) the health plan in which the person is enrolled agrees to pay the actual and full cost of the items and services provided. An individual who is eligible to enroll in Uniformed Services Health Plans but is not offered the opportunity to enroll in a Uniformed Services Health Plan and is not enrolled in an alliance health plan may enroll in a Uniformed Services Health Plan.

(g) If a person enrolled in the supplementary medical insurance program under Medicare part B enrolls in a Uniformed Services Health Plan, Medicare is responsible for making a premium payment on behalf of the person. Medicare must pay the Uniformed Services Health Plan on the same basis as it pays other eligible organizations with a risk-sharing contract under section 1876 of the Social Security Act. This premium payment is the person's exclusive benefit under Medicare.

(h) If an individual eligible to enroll in a Uniformed Services Health Plan enrolls in another alliance health plan, the Secretary may make a premium payment. In determining the amount of a payment, the Secretary considers the amount of any retiree discount payable under the Health Security Act on behalf of the person and the amount of any premium credits attributable to employer payments with respect to the person. The Secretary will not make a premium payment for any person enrolled in a health plan of the Department of Veterans Affairs or a health program of the Indian Health Service.

(i) An active duty member enrolled in a Uniformed Services Health Plan pays no premiums or cost sharing other than subsistence charges authorized by section 1075 of Title 10.

Spouses and children of active duty members and retirees may be required to pay the family share of premiums and cost sharing as established by regulation by the Secretary of Defense. These payments may not be higher than those charged by other

health plans. In addition, these payments in 1995 must not be higher than the lesser of the out-of-pocket costs owed by this group of individuals on December 31, 1994 and the amount charged by other health plans. The limitation on out-of-pocket costs may be adjusted for years after 1995 by an appropriate economic index, as determined by the Secretary of Defense.

(j) A financial account is established in the Department of Defense for all premium payments and other receipts from other payers and beneficiaries made in connection with any person enrolled in a Uniformed Services Health Plan. The account will be administered by the Secretary of Defense, and funds in the account may be used by the Secretary for any purpose directly related to the delivery and financing of health care services under chapter 55, including operations, maintenance, personnel, procurement, contributions toward construction projects, and related costs. Funds in the account remain available until expended.

(b) The term "Uniformed Services Health Plan" means a plan established by the Secretary of Defense to provide health care services to members of the uniformed services on active duty and other covered beneficiaries under chapter 55.

(c) If the Secretary of Defense chooses to establish any Uniformed Services Health Plans, the Secretary must submit to Congress a report describing the Plans. The report must be submitted not later than 30 days before the date on which the Secretary first issues proposed rules to establish any Plan.

SUBTITLE B - DEPARTMENT OF VETERANS AFFAIRS
(H.R. 3600 and S. 1757 p. 1218)

Section 8101. Benefits and Eligibility Through Department of Veterans Affairs Medical System (DVA).

(a) DVA as a Participant in Health Care Reform. This section amends Title 38, United States Code by inserting "Chapter 18 - Eligibility and Benefits Under Health Security Act" after chapter 17.

Definitions. Adds section 1801 that defines the following terms for the purposes of this chapter:

(1) A 'health plan' is an entity that has been certified under the Health Security Act as a health plan.

(2) A 'VA health plan' is a health plan operated by the Secretary of Veterans Affairs.

(3) A 'VA enrollee' is an individual enrolled in a VA health plan.

Subchapter II - Enrollment

Enrollment: Veterans. Adds section 1811 which states that each veteran who is eligible under the Health Security Act may enroll with a VA health plan. A veteran who selects a VA health plan must enroll.

Enrollment: CHAMPVA Eligibles. Adds section 1812 which states that an individual who is eligible for CHAMPVA and who is eligible under the Health Security Act may enroll in a VA health plan.

Enrollment: Family Members. Adds section 1813 which states that the Secretary may authorize a VA health plan to enroll members of the family of a veteran or CHAMPVA eligible enrollee and may charge premiums and cost sharing as required under the Health Security Act. An enrollee's family is the enrollee's spouse and children (and, if applicable, the spouse's children) if they are eligible individuals under the Health Security Act.

Subchapter III - Benefits

Benefits for VA Enrollees. Adds section 1821 which states that each VA health plan must provide the comprehensive benefit package to each enrollee.

Chapter 17 Benefits Described. Adds section 1822 which states that in addition to the comprehensive benefit package, the Secretary must provide the care and services authorized to be provided under chapter 17 according to current eligibility rules for those benefits.

Supplemental Benefits Packages and Policies. Adds section 1823 which states that a VA health plan may offer supplemental benefits policies for health care services not provided under chapter 17 and cost sharing policies consistent with the requirement of part 2 of Subtitle E of title I of the Health Security Act.

Limitation Regarding Veterans Enrolled With Health Plans Outside the Department. Adds section 1824 which states that a VA health plan may provide items and services in the comprehensive benefit package to veterans enrolled in non-VA health plans if the VA health plan is reimbursed for the actual and full costs of the care provided.

Subchapter IV - Financial Matters

Premiums, Copayments, etc. Adds section 1831 which provides that the Secretary may not impose premiums or cost sharing for the comprehensive benefit package on the following veterans who enroll in VA health plans:

(1) any veteran with a service-connected disability;

(2) any veteran whose discharge or release from the active military, naval or air service was for a disability incurred or aggravated in the line of duty;

(3) any veteran who is in receipt of, or who, but for a suspension pursuant to section 1151 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such a veteran's continuing eligibility for such care is provided for in such section;

(4) any veteran who is a former prisoner of war;

(5) any veteran of the Mexican border period or World War I; and

(6) any veteran who is unable to defray the expenses of necessary care as determined under section 1722(a) of this title.

The Secretary must charge premiums and cost sharing to other VA enrollees. Rates for cost sharing are established by the VA health plan based on rules of the health alliance.

Medicare Coverage and Reimbursement. Adds section 1832 in which VA health plans and Departmental facilities are deemed Medicare providers or eligible organizations under section 1876 of the Social Security Act.

The Secretary of Health and Human Services must reimburse a VA health plan or Department facility providing services as a Medicare provider or eligible organization under section 1876 on the same basis as other Medicare providers or eligible organizations for care provided to veterans other than veterans described in section 1831(b). The Secretary of Veterans Affairs must require that veterans other than veterans described in section 1831(b) pay any deductible or cost sharing that is not covered by Medicare.

Recovery of Cost of Certain Care and Services. Adds section 1833 in which the Secretary of Veterans Affairs has the right to recover or collect charges for care or services

provided to an individual covered under a supplemental insurance policy or a Medicare supplemental health insurance plan (but not including care or services for a service-connected disability) if the individual would be eligible to receive payment for such care or services if the care or services were not being provided by a department or agency of the United States. The provisions of subsections (b) through (f) of section 1729 of this title apply to claims under this section.

Revolving Fund. Adds section 1834 in which the Secretary of Veterans Affairs must establish a revolving fund. Any amount paid to the Department for the provision of health care by a VA health plan or the enrollment of an individual in a VA health plan must be credited to the revolving fund. The Department may not retain amounts received for care furnished to a VA enrollee in a case in which the costs of the care are covered by appropriations. Amounts in the revolving fund are available to the health plan for delivering the comprehensive benefit package and any supplemental benefits policy.

(b)Preservation of Existing Benefits for Facilities Not Operating as Health Plans. This section amends chapter 17 of title 38 by inserting section 1705 after section 1704.

Facilities Not Operating Within Health Plans; Veterans Not Eligible to Enroll in Health Plans. Inserts section 1705 in which the provisions of this chapter apply to: (1) any facility of the Department that is not operating as or within a health plan certified as a health plan within the Health Security Act; and (2) any facility providing care to any veteran who is living abroad and is therefore not an eligible individual under the Health Security Act.

Section 8102. Organization of Department of Veterans Affairs Facilities as Health Plans.

(a) In General. This section amends chapter 73 of title 38 by redesignating subchapter IV as subchapter V and by inserting after subchapter III the following new subchapter:

Subchapter IV - Participation as Part of National Health Care Reform

Organization of Department of Veterans Affairs Facilities as Health Plans. Adds section 7341 which states that the Secretary of Veterans Affairs must organize health plans and operate Department facilities as or within health plans. The Secretary must establish standards for the operation of Department health care facilities as or within health plans that conform, to the maximum extent practicable, to the requirements for health plans.

Health care facilities of the Department within a geographic region may be organized to operate as a single health plan encompassing all facilities or as several health plans.

In carrying out its responsibilities under the Health Security Act, a state (or state-

established entity) may not impose any standard or requirement or deny certification to a VA health plan because of a conflict with this section or any regulation prescribed pursuant to this section or other Federal law regarding the operation of this section.

Contract Authority for Facilities Operating as or Within Health Plans. Adds section 7342 in which the Secretary of Veterans Affairs may enter into a contract (without regard to laws requiring the use of competitive procedures) for the provision of services by a VA health plan if the Secretary determines that contracting is more cost effective than providing care directly through Department facilities or when contracting is necessary because of geographic inaccessibility.

Resource Sharing Authority: Facilities Operating as or Within Health Plans. Adds section 7343 which states that the Secretary of Veterans Affairs may enter into agreements for the sharing of resources of the Department through facilities of the Department operating as or within health plans.

Administrative and Personnel Flexibility. Adds section 7344 in which the Secretary of Veterans Affairs is given authority to carry out administrative reorganizations of the Department, enter into contracts for the performance of services previously performed by employees of the Department, and establish alternative personnel systems or procedures for personnel at facilities operating as or within health plans, except that the Secretary must comply with applicable veterans preference laws. The Secretary may also carry out appropriate promotional, advertising, and marketing activities to inform individuals of the availability of facilities of the Department operating as or within health plans. The Secretary must use only nonappropriated funds.

Veterans Health Care Investment Fund. Inserts section 7345 which states that: if amounts appropriated for each of the fiscal years 1995 through 1997 provide new budget authority for the Department of Veterans Affairs Medical Care account of no less than the amount requested by the President, the Secretary of the Treasury must credit to a special fund of the Treasury an amount equal to $1,000,000,000 for fiscal year 1995, $600,000,000 for fiscal year 1996, and $1,700,000,000 for fiscal year 1997. The amounts in the fund may be used only for the VA health plans authorized under this chapter.

By March 1, 1997, the Secretary must provide to Congress a report concerning the operation of the Department of Veterans Affairs health care system in preparing for, and operating under, health care reform during fiscal years 1995 and 1996. The report must include a discussion of the adequacy of amounts in the investment fund for the plans, the quality of care provided by the plans, the ability of the plans to attract new patients, and the need for additional funds for the investment fund in fiscal years after fiscal year 1997.

Funding Provisions: Grants and Other Sources of Assistance. Adds section 7346 in which the Secretary may apply for and accept, if awarded, any grant or other source of funding intended to meet the needs of special populations that but for this section is

unavailable to facilities of the Department or health plans operated by the Government if these funds will be used by a facility of the Department operating as or within a health plan.

(b) Clerical Amendment. The table of sections is amended at the beginning of chapter 73 to insert a table of contents for subchapter IV.

SUBTITLE C - FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (H.R. 3600 and S. 1757 p. 1233)

Section 8201. Definitions. This section defines the following terms for this subtitle:

(1) The term "abroad" means outside the United States.

(2) The terms "annuitant", "employee", and "Government", have the same respective meanings as are given such terms by section 8901 of title 5.

(3) The term "Employees Health Benefits Fund" means the fund under section 8909 of title 5.

(4) The term "FEHBP" means the health insurance program under chapter 89 of title 5.

(5) The term "FEHBP plan" has the same meaning as is given the term "health benefits plan" by section 8901(6) of title 5.

(6) The term "FEHBP termination date" means the date (specified in section 8202) after which FEHBP ceases to be in effect.

(7) The term "Retired Employees Health Benefits Fund" means the fund under section 8 of the Retired Federal Employees Health Benefits Act.

(8) The term "RFEHBP" means the health insurance program under the Retired Federal Employees Health Benefits Act.

Section 8202. FEHBP Termination. Chapter 89 of title 5 is repealed effective as of December 31, 1997, and all contracts under such chapter will terminate not later than that date.

Section 8203. Treatment of Federal Employees, Annuitants, and Other Individuals (Who Would Otherwise Have Been Eligible for FEHBP) Under Health Plans. This section sets forth rules applicable after the FEHBP termination date for eligible individuals who would have been eligible to enroll in a FEHBP plan before termination.

Federal employees will be treated as other employees (as defined in section 1901) under the Health Security Act, including for purposes of any requirements relating to enrollment and premium payments. Any employer premium payment required on behalf of a Federal employee must be paid from the appropriation or fund from which any Government contribution on behalf of such employee would have been payable under FEHBP.

The Federal Government shall offer to Federal employees one or more FEHBP supplemental plans.

The Office of Personnel Management (or other applicable Government entity) may, on the request of an annuitant enrolled in a health plan, withhold from the annuity of the annuitant any premiums required for enrollment. The Office (or other entity) must forward any amounts withheld to the appropriate fund or as otherwise indicated in the request.

In the case of an annuitant whose liability to the regional alliance is not reduced by employer premium payments, a Government contribution must be made to reduce the employee's liability to zero.

The Office of Personnel Management will develop one or more FEHBP supplemental plans that meet the requirements of supplemental health benefit policies or cost sharing policies under the Health Security Act and that reflect (taking into consideration the benefits in the comprehensive benefit package) the overall level of benefits last generally afforded under FEHBP. The Office of Personnel Management will also develop one or more Medicare supplemental plans that offer benefits which include the core group of basic benefits identified under section 1882(p)(2) of the Social Security Act and reflect (taking into consideration the benefits provided under the Medicare program) the overall level of benefits last generally afforded under FEHBP.

Each annuitant who was an annuitant or family member of an annuitant on December 31, 1997 is eligible to enroll in a FEHBP supplemental plan and is eligible for a Government contribution to premiums for a supplemental plan in an amount that reasonably reflects the portion of the Government contribution (last provided under FEHBP) attributable to the portion of FEHBP benefits which the plan is designed to replace.

The Federal Government shall offer future annuitants one or more FEHBP supplemental plans.

The Federal Government may, but is not required to, offer one or more FEHBP supplemental plans to any individual who would have been eligible to enroll in a FEHBP plan before termination, but would not have been eligible for a Government contribution. The Federal Government will not pay a Government contribution for these individuals.

Each Medicare-eligible annuitant who was Medicare-eligible on December 31, 1997 is eligible to enroll in a Medicare supplemental plan and, if that individual would have been eligible for a Government contribution under FEHBP, is eligible for a Government contribution to premiums for a Medicare supplemental plan and for a contribution that reasonably reflects the portion of the government contributions (last provided under FEHBP) attributable to the portion of FEHBP benefits which the plan is designed to replace.

The Federal Government may, but is not required to, offer one or more Medicare supplemental plans to any individual who was Medicare-eligible on December 31, 1997 and to make a Government contribution to the premium for the plan.

A Medicare-eligible individual may elect to have the amount of the Government contribution applied toward premiums for enrollment with an eligible organization under a risk-sharing contract under section 1876 of the Social Security Act. The amount of the Government contribution will be determined without taking into account this election.

The Government contributions authorized by this section on behalf of an annuitant (including payments to Medicare-eligible annuitants) must be paid from annual appropriations authorized to be made for that purpose and which may be made available until expended.

All contributions relating to any FEHBP supplemental plan, FEHBP Medicare supplemental plan or health insurance program covering FEHBP eligible individuals residing abroad must be paid into a fund established in the United States Treasury. The fund will be administered by the Office of Personnel Management and monies in the fund must be used for these plans and programs.

Section 8204. Treatment of Individuals Residing Abroad. After the FEHBP termination date, individuals residing abroad who would have been eligible for FEHBP continue to be eligible for health insurance under a program that the Office of Personnel Management will establish by regulation. Coverage and benefits under this program will, to the extent practicable, reflect the level of benefits available to individuals in the United States. Any Government contribution payable to a Federal employee under this program must be made from the appropriation or fund from which any Government contribution would have been payable under FEHBP.

Section 8205. Transition and Savings Provisions. The Employees Health Benefits Fund will be maintained, and amounts in the fund will remain available, after the FEHBP termination date, for a period of time that the Office of Personnel Management considers necessary to satisfy any outstanding claims.

After the end of this period, any amounts remaining in the Fund will be disbursed (between the Government and former participants in FEHBP) in accordance with a plan prepared by the Office of Personnel Management, consistent with the cost sharing ratio between the Government and plan enrollees during the final contract term. The details of the plan must be submitted to the President and the Congress at least one year before the date of its proposed implementation.

Chapter 89 of title V will be considered to remain in effect after the FEHBP termination date for the purposes of any liability incurred or violation which occurred before termination.

The Retired Federal Employees Health Benefits Act is repealed effective as of the FEHBP termination date. After the FEHBP termination date, the Retired Employees Health Benefits Fund will remain available temporarily and will then be disbursed in the same manner as the Employees Health Benefits Fund. Retired employees who would have been eligible for coverage under the Retired Federal Employees Health Benefits Act will be treated as if they were annuitants (subject to any differences in the level of coverage and benefits provided under FEHBP and RFEHBP).

Regulations concerning the disbursement of monies in any fund must make necessary

provisions for individuals residing abroad.

Section 8206. Regulations. The Office of Personnel Management must prescribe regulations to carry out this subtitle.

Section 8207. Technical and Conforming Amendments. The following technical and conforming amendments take effect on the day after the FEHBP termination date:

(1) The section of title 5 requiring the Office of Personnel Management to prepare an annual report on FEHBP is repealed.

(2) Any reference to a health insurance program under chapter 89 of title 5 will be considered a reference to the health insurance program under the Health Security Act, subject to clarifications and except as provided in regulations.

(3) Effective as of the date of the enactment of this Act, section 11101(b)(3) of the Omnibus Budget Reconciliation Act of 1993 is amended to substitute December 31, 1997 for September 30, 1998.

SUBTITLE D - INDIAN HEALTH SERVICE
(H.R. 3600 and S. 1757 p. 1249)

Section 8301. Definitions. This section defines the following terms for the purpose of this subtitle:

(1) The term "health program of the Indian Health Service" means a program which provides health services under this Act through a facility of the Indian Health Service, a tribal organization under the authority of the Indian Self-Determination Act or a self-governance compact, or an urban Indian program.

(2) The term "reservation" means the reservation of any federally recognized Indian tribe, former Indian reservations in Oklahoma, and lands held by incorporated Native groups, regional corporations, and village corporations under the provisions of the Alaska Native Claims Settlement Act.

(3) The term "urban Indian program" means any program operated pursuant to title V of the Indian Health Care Improvement Act.

(4) The terms "Indian", "Indian tribe", "tribal organization", and "service unit" have the same meaning as when used in the Indian Health Care Improvement Act.

Section 8302. Eligibility and Health Service Coverage of Indians. An eligible individual is eligible to enroll in a health program of the Indian Health Service, and may elect a health program of the Indian Health Service instead of a health plan, if the individual is: (1) an Indian, or a descendent of a member of an Indian tribe who belongs to and is regarded as an Indian by the Indian community in which the individual lives, who resides on or near an Indian reservation or in a geographical area designated by statute as meeting the requirements of being on or near a reservation notwithstanding the lack of an Indian reservation; (2) an urban Indian; or (3) a Indian living in certain counties in California as described in section 809(b) of the Indian Health Care Improvement Act.

An individual described above who elects a health program of the Indian Health Service must enroll in the program. The individual is not required to pay any health insurance premiums or other cost sharing. If an individual chooses not to enroll in a health program of the Indian Health Service and instead enrolls in an alliance health plan, the Indian Health Service does not pay the premiums and cost sharing required by the health plan.

Section 8303. Supplemental Indian Health Care Benefits. All individuals described in section 8302 remain eligible for supplemental benefits offered by the Indian Health Service at no charge. $180,000,000 for fiscal year 1995 and $200,000,000 for each of the fiscal years 1996 through 1999 are appropriated for supplemental benefits.

Section 8304. Health Plan and Health Alliance Requirements. Beginning on January 1, 1999, all health programs of the Indian Health Service must provide the comprehensive benefit package. The Secretary of Health and Human Services will determine which other health plan requirements will apply to health programs of the Indian Health Service. Beginning on January 1, 1999, all health programs of the Indian Health Service must meet the health plan requirements that the Secretary determines apply to Indian health programs. Before January 1, 1999, all health programs must, to the extent practicable, meet these requirements. The Secretary must also determine which requirements relating to health alliances apply to the Indian Health Service.

Section 8305. Exemption of Tribal Governments and Tribal Organizations from Employer Payments. Tribal governments and tribal organizations under the Indian Self-Determination and Educational Assistance Act or a self-governance compact are not required to make employer premium payments.

Section 8306. Provision of Health Services to Non-Enrollees and Non-Indians. A health program or facility of the Indian Health Service may contract with a health plan to provide services to individuals enrolled in that health plan if the program or facility determines that the contract will not result in a denial or diminution of health services to Indians enrolled in a health program of the Indian Health Service. The health program or facility is reimbursed as an essential community provider based on an alliance fee schedule or Medicare payment methodology and rates, as determined by the Secretary.

A health program of the Indian Health Service may open enrollment to family members of individuals described in section 8302. If the health program opens enrollment to family members, family members who choose to join a health program of the Indian Health Service must enroll. Family members must pay premiums and other cost sharing. The Secretary of Health and Human Services must establish and collect premiums for family members enrolled in health programs of the Indian Health Service.

The Secretary must provide for a process for premium reduction which is the same as the process used by regional alliances for the areas in which family members reside, but in computing the family share of the premiums the Secretary must use the lower of the premium quoted or the reduced weighted average accepted bid for the reference regional alliance. The Secretary must pay to each health program the amounts that would have been paid to a regional alliance if the individual had enrolled in a regional alliance health plan (with a final accepted bid equal to the reduced weighted average accepted bid premium for the regional alliance).

If a health program or facility of the Indian Health Service elects to be an essential community provider, an individual described in section 8302 or a family member of the individual may receive health services from that essential community provider.

Section 8307. Payment By Other Payers. Indian Health Service programs will continue to receive payments from other Federal programs and third party payers. The Indian Health Service continues to be the payer of last resort for Indians eligible for contract health services under a health program of the Indian Health Service.

Section 8308. Contracting Authority. The Indian Health Care Improvement Act is amended to permit contracting for personal services for the provision of direct health care services.

Section 8309. Consultation. The Secretary must consult with representatives of Indian tribes, tribal organizations, and urban Indian organizations annually concerning health care reform initiatives that affect Indian communities.

Section 8310. Infrastructure. The Secretary may expend funds appropriated under section 8313 for the construction and renovation of hospitals, health centers, health stations and other facilities for the purpose of improving and expanding these facilities to deliver the comprehensive benefit package. In order to enable health care facilities to deliver the package, the Secretary will establish a revolving loan program to provide guaranteed loans under terms and conditions determined by the Secretary to providers within the Indian Health Service.

Section 8311. Financing. Each health program of the Indian Health Service must establish a comprehensive benefit package fund. All employer premium payments, family premium payments and premium discount payments, appropriations for the purpose of delivering the comprehensive benefit package to enrollees in a health program of the Indian Health Service and any other amount received for the provision of the comprehensive benefit package must be deposited into the fund. Each fund is managed by the health program. Expenditures may be made from the fund for the delivery of the comprehensive benefit package. Amounts in the fund remain available without further appropriation and remain available until expended for payments for the delivery of the comprehensive benefit package.

Section 8312. Rule of Construction. Unless otherwise provided, no part of this act rescinds or modifies any obligations, findings or purposes contained in the Indian Health Care Improvement Act and in the Indian Self-Determination and Education Assistance Act.

Section 8313. Authorizations of Appropriations. For the purposes of carrying out this subtitle, there are authorized to be appropriated $40,000,000 for fiscal year 1995, $180,000,000 for fiscal year 1996, and $200,000,000 for each of the fiscal years 1997 through 2000. These appropriations are in addition to any other authorizations of appropriations that are available for carrying out this subtitle.

Section 8314. Payment of Premium Discount Equivalent Amounts for Unemployed Indians. The Secretary determines for each fiscal year beginning in fiscal year 1998 an amount equivalent to the total amount of premium discounts that would have been

paid to an individual described in section 8302 who is unemployed. The Secretary certifies this amount to the Secretary of the Treasury who pays the amount to the Indian Health Service.

Section 8403. Amendments Relating to Continuation of Coverage. (a) Amends section 602(2)(D) of ERISA to specify continuation coverage under a group health plan until health security act eligibility is established. Qualified individuals under section 602 shall not include any individuals eligible for coverage under the Health Security Act, and continuation coverage provisions are repealed as of the earlier of January 1, 1998, or the first day of the first calendar year in which individuals are eligible for coverage under a comprehensive benefit package.

Section 8404. Additional Amendments Relating to Group Health Plans. (a) Amends section 601(c) of ERISA to specify that regulations by the Board supersede ERISA rules with respect to adoption cases.

(b) The pediatric vaccine program under section 601(d) of ERISA shall not apply to any group health plan that becomes a corporate alliance plan under section 1311 of the Health Security Act.

Section 8405. Plan Claims Procedures. Section 503 of ERISA is amended by requiring group health plans to comply with the Health Security Act plan claims procedures under section 5201 of the Health Security Act.

Section 8406. Effective Dates. Except as otherwise provided, the effective date is January 1, 1998 or the date prescribed by the National Health Board in connection with plans whose participants reside in a state that becomes a participating state before the general effective date.

SUBTITLE F - SPECIAL FUND FOR WIC PROGRAM
(H.R. 3600 and S. 1757 p. 1274)

Section 8501. Additional Funding for Special Supplemental Food Program for Women, Infants and Children (WIC). This section establishes a special fund, in addition to regular appropriations otherwise available for WIC, to help ensure that the WIC program reaches full funding status at the end of FY 1996 and then remains at full funding levels. The President's budget submitted earlier this year set forth a path to full funding that included an appropriations level of $3.564 billion in FY 1995. This section provides that if in years after FY 1995, discretionary appropriations are provided equal to the $3.564 billion level adjusted for inflation, additional amounts from the special fund will be made available to provide the remaining amounts estimated to be needed for full funding.

This section appropriates for the WIC program the amounts necessary for the Secretary of the Treasury to credit to a special fund of the Treasury the following amounts: $254,000,000 for fiscal year 1996, $407,000,000 for fiscal year 1997, $384,000,000 for fiscal year 1998, $398,000,000 for fiscal year 1999 and $411,000,000 for fiscal year 2000. These funds, which are to be financed from "pay as you go" savings, are available only for the WIC program, exclusive of activities authorized under Section 17(m) of the Child Nutrition Act of 1966, and must be paid to the Secretary of Agriculture for that purpose. For each fiscal year, the amount credited to the fund is available only if discretionary appropriations for that year (that is, funds appropriated exclusive of amounts provided for the special fund) provide new budget authority for WIC of no less than $3,660,000,000 for fiscal year 1996, $3,759,000,000 for fiscal year 1997, $3,861,000,000 for fiscal year 1998, $3,996,000,000 for fiscal year 1999, and $4,136,000,000 for fiscal year 2000. The sum of these discretionary spending levels and the amounts from the special fund equals the amounts estimated to be needed for full funding of WIC.

In short, the Secretary of the Treasury is required to place specified amounts in a special fund each year and to pay these amounts to the Secretary of Agriculture for use in WIC, and Congress is authorized to provide the necessary appropriations for the Secretary of the Treasury to fulfill this requirement. These funds are available for use in WIC in a fiscal year only if regular discretionary appropriations for WIC in that year at least equal the levels specified in this section.

TITLE IX - AGGREGATE GOVERNMENT PAYMENTS

SUBTITLE A - AGGREGATE STATE PAYMENTS
(H.R. 3600 and S. 1757 p. 1277)

Subtitle A describes state maintenance of effort payments associated with Medicaid recipients not receiving cash assistance and state premium payments to regional alliances associated with persons receiving cash assistance.

PART 1 - STATE MAINTENANCE OF EFFORT PAYMENT

Part 1 describes state maintenance of effort payments associated with Medicaid recipients not receiving cash assistance.

Section 9001. State Maintenance Of Effort Payment Relating To Non-Cash Assistance Recipients. Participating states are required to make maintenance of effort payments based on current Medicaid expenditures for the comprehensive benefits package associated with recipients who are not receiving cash assistance.

For the first year of participation by a state, a state's payment is calculated as the sum of:

(A) The state's non-cash, non-disproportionate share (DSH) baseline amount (as determined under section 9002(a)(1)), updated under 9003(a)(1); and

(B) The state's non-cash, DSH baseline amount (as determined under section 9002(a)(2)), updated under section 9003(a)(2).

For a succeeding year, the state's payment is equal to the payment for the first year, updated under section 9003(b).

If a state has more than one regional alliance, the state's payments are divided among the state's regional alliances.

Section 9002. Non-Cash Baseline Amounts. The baseline amount is calculated in two parts: a non-cash, non-DSH amount and a non-cash, DSH amount.

The non-cash, non-DSH amount is the sum of:

(A) state Medicaid expenditures in fiscal year 1993 for the comprehensive benefits package for non-cash assistance children.

(B) state Medicaid expenditures in fiscal year 1993 for the comprehensive benefits package for non-cash assistance adults.

(C) state Medicaid expenditures in fiscal year 1993 for items and services that are not in the comprehensive benefits package and are not long-term care services for qualified children (under 1934(b)(1) of Title XIX, section 4222) who are AFDC or SSI recipients.

The non-cash, DSH amount is equal to the state share of disproportionate share expenditures in fiscal year 1993 (under section 1923 of the Social Security Act), multiplied by the proportion of state Medicaid expenditures for hospital services associated with recipients not receiving cash assistance.

Section 9003. Updating Of Baseline Amounts. Baseline amounts are updated separately to the first year of participation by a state, and then to subsequent years.

Updates from fiscal 1993 to the first year are as follows:

(1) The non-cash, non-DSH baseline amount is updated by the following percentages depending on the first year of participation by a state:

(A) 56.6 percent if the first year is 1996.

(B) 78.1 percent if the first year is 1997.

(C) 102.2 percent if the first year is 1998.

(2) The non-cash, DSH baseline amount is updated by the following percentages depending on the first year of participation by a state:

(A) 45.9 percent if the first year is 1996.

(B) 61.8 percent if the first year is 1997.

(C) 79.0 percent if the first year is 1998.

These percentages represent the projected increases nationwide in the relevant category of expenditures from fiscal year 1993 through the first year of participation.

For subsequent years, the non-cash baseline amount is updated by the general health care inflation factor (described in section 6001(a)(3)) plus projected U.S. population growth for the under-65 population.

Section 9004. Non-Cash Assistance Child And Adult Defined. Section 9004 defines child and adult Medicaid recipients who are not receiving cash assistance.

A non-cash assistance child means a child described in section 1934(b)(1) of the

Social Security Act (as inserted by section 4222(a)) who is not Medicare-eligible.

A non-cash assistance adult means an individual who is:

(1) Over 21 years,

(2) A citizen or national of the United States or an alien who is lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law, and

(3) Not an AFDC or SSI recipient or a Medicare-eligible individual.

PART 2 - STATE PREMIUM PAYMENTS

Part 2 describes state premium payments to regional alliances associated with persons receiving cash assistance.

Section 9011. State Premium Payments Relating To Cash Assistance Recipients. For each year, each participating state makes a premium payment for cash assistance recipients equal to 95% of the state medical assistance percentage times the sum of the following:

(1) The AFDC per capita premium amount for the regional alliance for the year (determined under section 9012(a)) times the number of AFDC recipients residing in the alliance area in the year (as determined under section 9014(b)(1)).

(2) The SSI per capita premium amount for the regional alliance for the year (determined under section 9013) times the number of SSI recipients residing in the alliance area in the year (as determined under section 9014(b)(1)).

A participating state's payment under this section is increased by the state medical assistance percentage times amounts attributable to AFDC and SSI recipients for cost sharing subsidies (under section 137(c)(1) and for increased premium discounts where an at-or-below-average cost plan is unavailable (under section 6104(b)(2)).

Section 9012. Determination Of AFDC Per Capita Premium Amount For Regional Alliances. The AFDC per capita premium amount for a regional alliance for a given year is equal to:

(1) Per capita state Medicaid expenditures for the year for the state in which the alliance is located, multiplied by

(2) An adjustment factor (determined under section 9015) for the year for the regional

alliance that is related to health care expenses in that alliance relative to the state as a whole.

Per capita state Medicaid expenditures for a state for a given year are equal to the state share of fiscal year 1993 Medicaid expenditures for the comprehensive benefits package associated with AFDC recipients, updated to the year as below.

Updates from fiscal year 1993 to the year before the first year of participation by a state is as follows:

(1) 32.2 percent if the first year is 1996.

(2) 46.6 percent if the first year is 1997.

(3) 62.1 percent if the first year is 1998.

These percentages are projected increases in per capita expenditures for AFDC recipients for services in the comprehensive benefits package from fiscal year 1993 to the calendar year before the first year of participation.

The Secretary of HHS shall estimate the rate of increase in per capita state Medicaid expenditures between fiscal year 1993 and the year before the first year for a state, adjusting the estimate to eliminate any change in expenditures that results from a reduction in the scope of services, arbitrary reduction in payment rates, or a reduction in access to high quality services. If the estimated rate of increase is less than the percentage amounts specified above, then the Secretary shall update the fiscal year 1993 per capita expenditures by the estimated increase for the state rather than the percentages specified above

Updates from the year before the first year of participation by a state to a subsequent year are equal to the general health care inflation factor for the year (as defined in section 6001(a)(3)).

Section 9013. Determination Of SSI Per Capita Premium Amount For Regional Alliances. The SSI per capita premium amount for a regional alliance for a given year is determined in the same way as the AFDC per capita premium amount, except with respect to SSI recipients instead of AFDC recipients and with different update percentages.

Updates from fiscal year 1993 to the year before the first year of participation by a state with respect to the SSI per capita premium amount are as follows:

(1) 29.4 percent if the first year is 1996.

(2) 43.7 percent if the first year is 1997.

state payment levels, taking into account the revenue base in each state.

Section 9023. Special Rules For Puerto Rico And Other Territories. Subject to guidelines described in this section, the Secretary may waive or modify financial requirements for participating states with respect to Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands to accommodate their unique geographic and social conditions and features of their health care systems.

SUBTITLE B - AGGREGATE FEDERAL ALLIANCE PAYMENTS (H.R. 3600 and S. 1757 p. 1296)

Subtitle B describes payments by the Federal Government to alliances for the federal share of premiums for AFDC and SSI recipients and for business and family discounts.

Section 9101. Federal Premium Payments For Cash Assistance Recipients. The Secretary of HHS must make payments each year to each regional alliance for the Federal share of premium payments and certain discounts for AFDC and SSI recipients. The payment is calculated in the same manner as a state's payment (described in section 9011), except that the Federal medical assistance percentage (defined in section 1905(b) of the Social Security Act) is used instead of the state medical assistance percentage.

Federal payments must be made on a periodic basis, reflecting the cash flow requirements of regional alliances. Each regional alliance must provide the Secretary with information necessary to make these payments.

Federal payments are reconciled based on information provided by states, subject to audit by the Secretary.

Section 9102. Capped Federal Alliance Payments.

(a) CAPPED ENTITLEMENT: Beginning January 1, 1996, the Secretary must provide to each regional alliance payments for family and employer discounts ("capped Federal alliance payment amount," as defined in this section). The total amount of these payments is a capped entitlement.

(b) CAPPED FEDERAL ALLIANCE PAYMENT AMOUNT: The capped Federal alliance payment amount is determined on a quarterly basis, and is equal to the payment obligations of the alliance minus amounts receivable by the alliance subject to the cap as set forth in subsection (e). Payment obligations include payments to plans, payments for cost sharing reductions, and alliance administrative expenses. Amounts receivable by the alliance include premiums owed by families and employers (not taking into account amounts that are owed but not paid) and amounts payable by Federal and state Governments for maintenance of effort and for per capita premium amounts for AFDC and SSI recipients.

The Federal Government is not responsible for amounts owed to an alliance but not collected, for administrative errors in providing discounts that exceed maximum permissible error rates (specified in section 1361(b)(1)(C)), or for misappropriations or other regional alliance expenditures that the Secretary finds are attributable to malfeasance or misfeasance by the regional alliance or the state.

For a single-payer state, the Secretary must pay an amount equal to what regional alliances in the state would have received under this section if the state were not a single-

payer state.

(c) DETERMINATION OF CAPPED FEDERAL ALLIANCE PAYMENT AMOUNTS: Before the beginning of each year, the Secretary must estimate the capped Federal alliance payment amount for each regional alliance. The Secretary must report to Congress an estimate of the total capped Federal alliance payment amounts owed for all alliances.

(d) PAYMENTS TO REGIONAL ALLIANCES: The capped Federal alliance payment amount must be made on a periodic basis, reflecting the cash flow requirements of regional alliances. Each regional alliance must provide the Secretary with information necessary to make these payments.

(e) CAP ON PAYMENTS: The total amount of the capped Federal alliance payments for a fiscal year may not exceed the caps specified in this section.

For fiscal years 1996 through 2000, the caps are as follows:

(1) $10.3 billion for fiscal year 1996.

(2) $28.3 billion for fiscal year 1997.

(3) $75.6 billion for fiscal year 1998.

(4) $78.9 billion for fiscal year 1999.

(5) $81.0 billion for fiscal year 2000.

If the CPI is projected to be significantly different from what was projected by the Council of Economic Advisors to the President as of October 1993, the Secretary may adjust the caps so as to reflect the different inflation assumption.

For subsequent fiscal years, the cap from the previous year is updated by a formula that is based on increases in the CPI, U.S. population, and real per capita Gross Domestic Product.

If total capped Federal alliance payment amounts are less than the cap for a fiscal year, the surplus is accumulated and made available for future years.

If the Secretary anticipates that the amount of the cap, plus any amount carried forward from a previous year, will not be sufficient for a fiscal year, the Secretary must notify the President, the Congress, and each regional alliance of the anticipated shortfall and when the shortfall will first occur.

Within 30 days of receiving notice from the Secretary, the President must submit to Congress a report containing specific legislative recommendations for actions which would eliminate the shortfall.

The President's report is considered under an expedited process. If a joint resolution is introduced that contains the President's recommendations, that resolution is considered in a manner described in the Defense Base Closure and Realignment Act of 1990.

SUBTITLE C - BORROWING AUTHORITY TO COVER CASH-FLOW SHORTFALLS
(H.R. 3600 and S. 1757 p. 1308)

Section 9201. Borrowing Authority To Cover Cash-Flow Shortfalls. (a) Authorizes the Secretary to make loans available to regional alliances in order to cover temporary cash-flow shortfalls attributable to:

(1) estimation discrepancies,
(2) administrative errors,
(3) the relative timing during the year in which amounts are received and payments are required to be made.

(b) Requires that loans made to regional alliances under this section be under terms and conditions specified by the Secretary, in consultation with the Secretary of the Treasury, that take into account Treasury cash management rules. Loans under this section are repayable over a period of no more than 2 years. Alliances pay interest on the loans at a rate of interest determined by the Secretary of the Treasury. The Secretary takes into consideration the current average rate on outstanding marketable obligations of the United states in determining the interest rate.

As a condition of receiving a loan under this section, a regional alliance must agree to make appropriate adjustments (as described in subsection (f)) to future premiums or collections to assure the repayment of the amount so borrowed.

(c) Sets forth the manner for repayment of loans under this section. Loans to regional alliances for shortfalls that result from estimation discrepancies of timing or receipts are repaid through a reduction in the payment amounts made to regional alliances under section 9102. Loans for shortfalls that result from administrative error are repaid through a temporary increase in the amount of the state maintenance-of-effort payment required under section 9001.

(d) Requires the Secretary to make annual reports to Congress on the loans made (and loan amounts repaid) under this section.

(e) More precisely describes the purposes for which loans are available under this section.

The estimation discrepancies referred to in this section are discrepancies in estimating the following:

(1) the average premium payments per family under section 6122(b).
(2) the AFDC and SSI proportions under section 6202.
(3) the distribution of enrolled families in different risk categories for purposes of under section 1343(b)(2).

(4) the distribution of enrollment in excess premium plans.
(5) the collection shortfalls (used in computing the family collection shortfall add-on under section 6107).

The administrative errors referred to in this section include the following:

(1) an eligibility error rate for premium discounts and liability reductions that exceeds the maximum permissible error rate established for the alliance.
(2) misappropriations or other regional alliance expenditures that are determined to be attributable to malfeasance or misfeasance by the regional alliance or the state.

(f) Describes the estimation adjustment provisions that an alliance must agree to follow as a condition of receiving a loan under this section:

(1) adjustments for average premium payments per family under section 6122(b)(4).
(2) adjustments in the AFDC and SSI proportions under section 6202(d).
(3) adjustments pursuant to methodology described in section 1541(b)(8).
(4) adjustments in excess premium credit pursuant to section 6105(b)(2).
(5) adjustment in the collection shortfall add-on under section 6017(b)(2)(C)).

(g) Authorizes the Secretary of the Treasury to advance to the Secretary amounts sufficient to cover the loans made under this section. The amount of advances outstanding at any time may not exceed $3,500,000,000.

TITLE X - COORDINATION OF MEDICAL PORTION OF WORKERS COMPENSATION AND AUTOMOBILE INSURANCE

SUBTITLE A - WORKERS COMPENSATION INSURANCE (H.R. 3600 and S. 1757 p. 1314)

Section 10000. Definitions.

The term ''injured worker'' is defined to mean an individual enrolled under a health plan who has a work-related injury or illness for which workers compensation medical benefits are available under state law.

The term ''specialized workers compensation provider'' is defined to mean a health care provider that specializes in the provision of treatment relating to work-related injuries or illness (including specialists in industrial medicine, specialists in occupational therapy and centers of excellence in industrial medicine and occupational therapy).

The term ''workers compensation medical benefits'' is defined to mean the comprehensive medical benefits for work-related injuries and illnesses provided for under the workers compensation laws of a state to an injured worker.

The term ''workers compensation carrier'' is defined to mean an insurance company that underwrites workers compensation medical benefits, including an employer or fund that is financially at risk for the provision of workers compensation medical benefits.

The term ''workers compensation services'' is defined to mean items and services included in workers compensation medical benefits and includes items and services (including rehabilitation services and long-term care services) commonly used for treatment of work-related injuries and illnesses.

PART 1 - HEALTH PLAN REQUIREMENTS RELATING TO WORKERS COMPENSATION

Section 10001. Provision Of Workers Compensation Services. (a) Requires each health plan that provides services to enrollees through participating providers to enter into contracts and arrangements to provide or arrange for the provision of workers compensation services to such enrollees. Payments for workers compensation services are made by workers compensation carriers under section 10002.

Services may be provided or arranged by the health plan through:

(1) A participating provider in the plan;

(2) Another provider with whom the plan has entered into an agreement for the provision of such services, or

(3) A specialized workers compensation provider (designated by the state under 10011).

Individuals who are entitled to workers compensation medical benefits generally must receive workers compensation services through the health plan in which they are enrolled. This requirement applies without regard to whether the health plan uses participating providers to provide health benefits to its enrollees. This requirement does not apply in the case of an injured worker who needs emergency services or to certain electing veterans, active duty military personnel, and Indians as described in section 1004(b).

(b) Permits an injured worker and a workers compensation carrier to agree to the provision of workers compensation services in a manner other than by or through the health plan in which the worker is enrolled.

(c) Requires each health plan to employ or contract one or more individuals with experience in the treatment of occupational illness and injury to provide case management services to injured workers enrolled in the plan. The case manager is responsible for ensuring that:

(1) there is a plan of treatment (when appropriate) for each enrollee who is an injured worker designed to assure appropriate treatment and facilitate return to work;
(2) the plan of treatment is coordinated with the workers compensation carrier and the employer;
(3) the health plan (and its providers) comply with legal duties and requirements under state law; and
(4) the injured worker is referred to appropriate providers (when necessary).

Section 10002. Payment By Workers Compensation Carrier. (a) Provides that payment for workers compensation services by workers compensation carriers generally will be made in accordance with the applicable regional alliance fee schedule established under section 1322(c) or the state fee schedule established under section 10013.

(b) Permits an alliance or state to establish an alternative payment methodology (such as payment on a negotiated fee for each case) for payment for workers compensation services. Workers compensation carriers and health plans also are permitted to negotiate alternative payment arrangements.

(c) Provides that this subpart may not be construed to require an injured worker to make any payment (including payment of any cost sharing or any amount in excess of the applicable fee schedule) to any health plan or health care provider for the receipt of workers compensation services.

PART 2 - REQUIREMENTS OF PARTICIPATING STATES

Section 10011. Coordination Of Specialized Workers Compensation Providers. (a) Requires each participating state to coordinate access to specialized workers compensation providers on behalf of health plans providing coverage to individuals residing in the state.

(b) Authorizes states to designate specialized workers compensation providers to provide workers compensation services with respect to one or more types of injuries or illnesses for a geographic area that are:

(1) not included in the comprehensive benefit package; or
(2) specialized services that are typically provided (as determined by the state) by specialists in occupational or rehabilitative medicine.

Injured workers and health plans are authorized to use providers designated under this subsection.

Section 10012. Preemption Of State Laws Restricting Delivery of Workers Compensation Medical Benefits. (a) Provides that no state law will have any effect that restricts the choice, or payment, of providers that may provide workers compensation services for individuals enrolled in a health plan.

(b) Preserves the authority of state law to provide for a method for resolving disputes among parties related to:

(1) an individual's entitlement to workers compensation medical benefits under state law;
(2) the necessity and appropriateness of workers compensation services provided to an injured worker; and
(3) the reasonableness of charges or fees charged for workers compensation services (subject to the requirements of this subpart related to the use of alliance and state fee schedules).

Section 10013. Development Of Supplemental Schedule.
Each participating state is required to develop a fee schedule for workers compensation services for which a fee is not included in the applicable regional alliance fee schedule.

Section 10014. Construction. (a) Provides that this subtitle should not be construed as altering:

(1) the effect of a state workers compensation law as the exclusive remedy for work-related injuries or illnesses;

Section 10031. Authorization.

This section authorizes the Secretary of Health and Human Services and the Secretary of Labor to conduct demonstration projects under this part in one or more states with respect to treatment of work-related injuries and illnesses.

Section 10032. Development Of Work-Related Protocols. (a) Authorizes the Secretary of Health and Human Services and the Secretary of Labor, in consultation with states and others, to develop protocols for the appropriate treatment of work-related conditions.

(b) authorizes the Secretaries to enter into contracts with one or more health alliances to test the validity of the protocol.

Section 10033. Development Of Capitation Payment Models.

This section authorizes the Secretary of Health and Human Services and the Secretary of Labor to develop (using protocols developed under the previous section) methods of providing for payment by workers compensation carriers to health plans on a per case, per capita payment for the treatment of specified work-related injuries and illnesses.

SUBTITLE B - AUTOMOBILE INSURANCE
(H.R. 3600 and S. 1757 p. 1326)

Section 10100. Definitions.

The term ''injured worker'' is defined to mean an individual enrolled under a health plan who has an injury or illness sustained in an automobile accident for which automobile insurance medical benefits are available.

The term automobile insurance medical benefits is defined to mean the comprehensive medical benefits for injuries or illnesses sustained in automobile accidents.

The term ''automobile insurance carrier'' means an insurance company that underwrites automobile insurance medical benefits and includes an employer or fund that is financially at risk for the provision of automobile insurance medical benefits.

The term "automobile insurance medical services'' means items and services included in automobile insurance medical benefits and includes items and services (such as rehabilitation services and long-term care services) commonly used for treatment of injuries and illnesses sustained in automobile accidents.

PART 1 - HEALTH PLAN REQUIREMENTS RELATING TO AUTOMOBILE INSURANCE

Section 10101. Provision Of Automobile Insurance Medical Benefits Through Health Plans. (a) Provides that an individual entitled to automobile insurance medical benefits and enrolled in a health plan will receive automobile insurance medical services through the provision (or arrangement for the provision) of such services by the health plan.

(b) Requires health plans to make necessary referrals for automobile insurance medical services as may be necessary to assure appropriate treatment of injured individuals.

(c) Provides that the requirements of this section do not apply to certain electing veterans, active duty military personnel, and indians as described in section 1004(b).

(d) Permits an injured individual and an automobile insurance carrier to agree to the provision of automobile insurance medical services in a manner other than by or through the health plan in which the worker is enrolled.

Section 10102. Payment By Automobile Insurance Carrier. (a) Provides that payment for automobile insurance medical services by automobile insurance carriers generally will be made in accordance with the applicable regional alliance fee schedule

SUBTITLE C - COMMISSION ON INTEGRATION OF HEALTH BENEFITS (H.R. 3600 and S. 1757 p. 1331)

Section 10201. Commission.
This section establishes the Commission on Integration of Health Benefits.

The Commission will consist of 15 members appointed jointly by the Secretaries of Health and Human Services and the Secretary of Labor. Members of the Commission will serve without compensation. The Secretaries provide that each member shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

The Commission is directed to study the feasibility and appropriateness of transferring financial responsibility for all medical benefits (including those currently covered under workers compensation and automobile insurance) to health plans. Staff support for the Commission is provided by the Secretaries.

The Commission must submit a report to the President by not later than July 1, 1995. If the Commission recommends the integration of financial responsibility for all medical benefits in health plans, the report must contain a detailed plan as to how (and when) such an integration should be effected under this Act.

The Commission shall terminate 90 days after the date of submission of its report. Appropriation of the amounts necessary to carry out this section are authorized under the section.

SUBTITLE D - FEDERAL EMPLOYEES' COMPENSATION ACT (H.R. 3600 and S. 1757 p. 1333)

Section 10301. Application Of Policy.
This section makes technical changes to the Federal Employees' Compensation Act (Chapter 81 of title 5, United States Code) to conform it to the changes made to state workers compensation systems under subtitle A.

SUBTITLE E - DAVIS-BACON ACT AND SERVICE CONTRACT ACT (H.R. 3600 and S. 1757 p. 1333)

Section 10401. Coverage Of Benefits Under Health Security Act.
This section make technical changes to the Section 1(b)(2) of the Davis Bacon Act (40

U.S.C. 276a(b)(2)) and to the second sentence of section 2(a)(2) of the Service Contract Act of 1965 (41 U.S.C. 351(a)(2)). The amendments insert after ''local law'' the following: ''(other than benefits provided pursuant to the Health Security Act)''.

SUBTITLE F - EFFECTIVE DATES
(H.R. 3600 and S. 1757 p. 1334)

Section 10501. Regional Alliances.

The section provides that the provisions of subtitles A and B of this title will apply to regional alliances and regional alliance health plans in a state 2 years after the state's first year (as defined in section 1902(17)).

Section 10502. Corporate Alliances.

The section provides that the provisions of subtitles A and B of this title will apply to corporate alliances and corporate alliance health plans on January 1, 1998.

Section 10503. Federal Requirements.

The section provides that the provisions of subtitle D of this title will take effect on January 1, 1998.

TITLE XI - TRANSITIONAL INSURANCE REFORM
(H.R. 3600 and S. 1757 p. 1335)

Section 11001. Imposition Of Requirements. (a) Provides that the purpose of the title is to assure, to the extent possible, the maintenance of current health care coverage and benefits during the period between the enactment of the Health Security Act and the dates its provisions are implemented in the various states.

(b) Provides that the Secretary of Health and Human Services will enforce the requirements of the title with respect to health insurance plans and that the Secretary of Labor will enforce the requirements with respect to self-funded health plans. Each Secretary is required to promulgate regulations to carry out the requirements under this title. Regulations for carrying out section 11004 must be promulgated within 90 days after the date of the enactment of the Act.

The Secretaries are authorized to enter into arrangements with a state to enforce the requirements of this title with respect to health insurance plans and self-insured plans providing coverage in the state.

(c) Provides that the requirements of the title do not preempt any state law unless state law directly conflicts with such requirements. State laws that provide additional protection to consumers will not be considered to directly conflict with the requirements of the title. Each Secretary may issue letter determinations with respect to whether this Act preempts a provision of state law.

(d) Provides that regulations issued to carry out this title may be issued as interim final regulations. The Secretary is authorized to consult with states and the National Association of Insurance Commissioners in issuing regulations and guidelines under this title.

(e) Provides that this title will be construed, to the greatest extent practicable, to assure the continuity of health benefits provided under health benefit plans in effect on the effective date of this Act.

(f) Authorizes the Secretary to issue regulations relating to the application of this title when health insurance plans are transferred from one insurer to another insurer through assumption, acquisition, or otherwise.

Section 11002. Enforcement. (a) Provides that a health insurer or health benefit plan sponsor that violates a requirement of this title is subject to civil money penalties of not more than $25,000 for each such violation.

(b) Authorizes the appropriate Secretary to bring a civil action to enjoin any act or practice which violates any provision of this title or to obtain other appropriate equitable

relief to redress violations or enforce any provision of this title.

Section 11003. Requirements Relating To Preserving Current Coverage.

(a) Generally prohibits health insurers from terminating (or failing to renew) coverage under a group or individual health insurance plan except in the cases of:

(1) nonpayment of required premiums;
(2) fraud; or
(C) misrepresentation of a material fact relating to an application for coverage or claim for benefits.

The provisions of this subsection take effect on the date of enactment and apply to coverage on or after such date.

(b) Requires health insurers that provide group health insurance plans to provide coverage to new full-time employees (and their eligible dependents) of any employer covered under the plan. Premium rates for new employees must be consistent with the provisions of section 11004(b) and any exclusions imposed for preexisting conditions must meet the requirements of section 11005.

Section 11004. Restrictions On Premium Increases During Transition.

This section establishes requirements relating to premium increases by health insurers during the transition period.

(a) Requires health insurers to divide their health insurance business into three sectors for the purpose of calculating rate increases: a large group sector (which applies to groups with 100 or more covered lives); a small group sector (which applies to groups with fewer than 100 covered lives) and an individual sector.

(b) Establishes requirements for changes in premiums relating to changes in individual or group characteristics. The subsection applies to changes in premiums for:

(1) changes in the number of individuals covered under a plan;
(2) changes in the demographic or group characteristics (including age, gender, family composition or geographic area but not including health status, claims experience or duration of coverage under the plan) of individuals covered under a plan;
(3) changes in the level of benefits under the plan; and
(4) changes in any material terms and conditions of the health insurance plan (not related to health status).

Health insurers that increase premiums are required to calculate a reference rate for each such sector. The reference rate for a sector is calculated so that when applied to the rate factors (specified in the subsection) it would approximate the average premium rates charged

individuals and groups in the sector as of the effective date of this title.

Health insurers that increase premiums are also required to develop a single set of rate factors for each sector. The rate factors are used to calculate changes in premium that relate to changes in group or individual characteristics, changes in benefits or material changes in the terms of the plan.

Rate factors developed by insurers must relate to reasonable and objective differences in demographic characteristics, in the design and in levels of coverage, and in other terms and conditions of a contract and may not relate to expected health status, claims experience, or duration of coverage of the one or more groups or individuals.

Changes in premiums are calculated using the rate factors developed pursuant this section.

For changes in premium rates that relate to a change in the number of people covered under a health insurance plan, the premium change is calculated by applying the reference rate (for the sector) to the rate factors applicable to the people who joined or left the plan.

For changes in premium rates that relate to changes in group or individual characteristics, changes in benefits or material changes in the terms of the plan, the premium changes are calculated by applying the rate factors developed pursuant to this subsection applied to the current premium charged for the health insurance plan.

In applying rate factors under this subsection, resulting changes in premium may not reflect any change in the health status, claims experience or duration of coverage with respect to any employer or individual covered under the plan.

The provisions of this subsection apply only:

(1) to changes in premiums occurring on or after the date of the enactment of this Act to groups and individuals covered as of that date, or

(2) for groups and individuals covered after the date of enactment, to changes in premiums after the date coverage begins.

This subsection does not require the application of rate factors related to individual or group characteristics with respect to community-rated plans.

(c) Establishes limitations on changes in premiums related to increases in health care costs and utilization.

In general, health insurers that increase premiums because of increases in costs or utilization must apply the same percentage increase to all plans in all sectors. Health insurers may vary the percentage increase among plans in the large group sector, based on

the credible claims experience of particular employers, as long as the weighted average of increases for all such plans in the sector is equal to the percentage increase in other sectors.

Premium increases under this subsection may be applied on a national level or may vary based on geographic area. Area variations may be applied only if the areas are sufficiently large to provide credible data on which to calculate the variation and the variation is due to reasonable factors related to the objective differences among the areas in costs and utilization of health services.

The Secretary is authorized to grant exceptions to the limitations on rate increases contained in this subsection to accommodate state insurance reform efforts if necessary to permit a state to narrow the variations in premiums among health insurance plans offered by health insurers to similarly situated groups or individuals within a sector.

The limitations on rate increases contained in this subsection do not apply to premium rates that are subject to prior approval by a state insurance commissioner (or similar official) and are in fact approved by such official.

The Secretary is authorized to specify other exceptions through regulations that the Secretary determines are required to enhance stability of the health insurance market and continued availability of coverage.

Premium increases must be applied in a consistent, even manner so that any variations in the rate of increase applied in consecutive months are even and continuous during the year.

A health insurer may petition for an exception from the application of the provisions of this subsection. The Secretary may approve grant an exception if the health insurer demonstrates that the application of this subsection would threaten the financial viability of the insurer and the health insurer offers an alternative method for increasing premiums that is not substantially discriminatory to any sector or to any group or individual covered by a health insurance plan offered by the insurer.

(d) Requires health insurers to obtain prior approval for proposed premium increases for the individual and small group sector if the proposed premium increase exceeds a percentage specified by the Secretary.

In specifying a percentage under this subsection, the Secretary must consider the rate of increase in health care costs and utilization, previous trends in health insurance premiums, and the conditions in the health insurance market. The Secretary must specify a percentage within 30 days after the date of the enactment of the Act.

(e) Requires that premiums for each health plan be conformed in a manner that complies with the provisions of this section within one year after the date of enactment of the

Act.

Health insurers are required to document the methodology used in applying limitations to premium increases under subsections (b) and (c). The documentation must be sufficient to permit the auditing of the application of the methodology used to determine consistency with the requirements of the section.

Health insurers must file a certification with the Secretary every six months certifying compliance with the requirements of the section.

(f) Requires the Secretary to establish regulations to carry out this section. The regulations may specify the permissible variation that results from the use of demographic or other characteristics in the development of rate factors. The guidelines may be based on the guidelines currently used by states in applying rate limitations under state insurance regulations.

(g) Provides that the section will apply to premium increases occurring during the period beginning on the date of the enactment of the Act and ending on the date a state implements universal coverage through alliances under the provisions of the Act.

Section 11005. Requirements Relating To Portability. (a) Limits the period of exclusion that a group health benefit plan may apply with respect to services related to treatment of a preexisting condition to a period of not more than 6 months. An exclusion of coverage for treatment of a preexisting condition may not apply to services furnished to newborns or in the case of a plan that did not apply such exclusions as of the effective date of this title.

A group health benefit plan must reduce any period of exclusion applied with respect to treatment of a preexisting condition for individuals that were previously covered by health insurance. The amount of reduction is one month for each month of previous coverage. The previous coverage must have been continuous (with no more than three consecutive months without coverage).

(b) Provides that self-insured plans and employers sponsoring group health insurance plans may not discriminate among employees in the establishment of waiting periods for health insurance on the basis of health status or related factors.

Section 11006. Requirements Limiting Reduction Of Benefits.

The section prohibits a sponsor of a self-insured benefit plan from modifying benefits under the plan in a manner that reduces or limits coverage with respect to any medical condition or course of treatment for which the anticipated cost is likely to exceed $5,000 in any 12-month period.

A modification of benefits includes the termination of a plan if the sponsor establishes

a substitute plan that reflects such a reduction or limitation.

A modification made in violation of this section is not effective and the self-insured sponsor must continue to provide benefits as though the modification (described in subsection (b)) had not occurred.

Section 11007. National Transitional Health Insurance Risk Pool.

(a) Authorizes the Secretary to establish a National Transitional Health Insurance Risk Pool ("national risk pool") during the transition.

(b) Authorizes the Secretary to administer the national risk pool through contracts with state health insurance risk pools, private health insurers, or other contractors as the Secretary deems appropriate.

The Secretary is authorized to enter into such arrangements with existing state health insurance risk pools to coordinate the coverage under such pools with the coverage under the national risk pool.

(c) Provides that coverage under the national risk pool may be provided to individuals who are unable to secure health insurance coverage from private health insurers because of their health status or condition (as determined in accordance with rules and procedures specified by the Secretary).

(d) Provides that the benefits and terms of coverage provided through the national risk pool will include items and services, conditions of coverage, and cost sharing (subject to out-of-pocket limits on cost sharing) comparable to the benefits and terms of coverage available in state health insurance risk pools.

Payments to providers by the national risk pool for covered items and services will be made at rates specified by the Secretary based on payment rates for comparable items and services under the Medicare program. Providers who accept payment from the national risk pool must accept the payment as payment in full.

(e) Provides for premiums for coverage in the national risk pool to be set in a manner specified by the Secretary. Premiums vary based upon age, place of residence, and other traditional underwriting factors other than on the basis of health status or claims experience. Premiums charged individuals must be set at a level that is no less than 150 percent of the premiums that the Secretary estimates would be charged to a population of average risk for the covered benefits.

(f) Requires the Secretary to estimate each year the extent to which the total premiums collected by the national risk pool are insufficient to cover the expenses of the national risk pool with respect to the year. The Secretary of the Treasury is authorized to

advance to the Secretary amounts sufficient to cover the amount estimated.

The Secretary must repay such amounts, with interest at a rate specified by the Secretary of the Treasury, from the assessments made on health benefit plan sponsors. Assessments on health benefit plans in a year may not exceed 1/2 of 1 percent of the total amount of premiums (and premium equivalents in the case of self-insured plans) for health benefits under the plan for the previous year.

Section 11008. Definitions.

The term "applicable Secretary" means the Secretary of Health and Human Services with respect to health insurance plans and insurers and the Secretary of Labor with respect to self-insured plans and self-insured plan sponsors.

The term "covered employee" means an employee (or dependent of such an employee) covered under a group health benefits plan.

The term "covered individual" means an individual insured, enrolled, eligible for benefits, or otherwise covered under a health benefit plan.

The term "group health benefits plan" means a group health insurance plan and a self-insured plan.

The term "group health insurance plan" means a health insurance plan offered primarily to employers for the purpose of providing health insurance to the employees (and dependents) of the employer. The term includes arrangements offered through associations and trusts, and includes a multi-employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974), whether funded through insurance or otherwise.

The term "health benefits plan" means health insurance plan and a self-insured health benefit plan.

The term "health benefit plan sponsor" means the insurer offering a health insurance plan or the self-insured sponsor for a self-insured plan.

The term "health insurance plan" means any contract of health insurance, including any hospital or medical service policy or certificate, any major medical policy or certificate, any hospital or medical service plan contract, or health maintenance organization subscriber contract offered by an insurer. The term does not include any of the following:

(1) coverage only for accident, dental, vision, disability income, or long-term care insurance;

(2) Medicare supplemental health insurance;

(3) coverage issued as a supplement to liability insurance;

(4) worker's compensation or similar insurance; or
(5) automobile medical-payment insurance.

The term also does not include any aggregate or specific stop-loss insurance or similar coverage applicable to a self-insured plan. The Secretary is authorized to develop rules determining the applicability of this subparagraph with respect to minimum premium plans or other partially insured plans.

The term "health insurer" means a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, or other entity providing a plan of health insurance or health benefits with respect to which the state insurance laws are not preempted under section 514 of the Employee Retirement Income Security Act of 1974.

The term "individual health insurance plan" means any health insurance plan directly purchased by an individual or offered primarily to individuals (including families) for the purpose of permitting individuals (without regard to an employer contribution) to purchase health insurance coverage. The includes any arrangement in which coverage for health benefits is offered to individuals through an association, trust, list-billing arrangement, or other arrangement in which the individual purchaser is primarily responsible for the payment of any premium associated with the contract.

The term "self-insured plan" means an employee welfare benefit plan or other arrangement insofar as the plan or arrangement provides benefits with respect to some or all of the items and services included in the comprehensive benefit package (as in effect as of January 1, 1995) that is funded in a manner other than through the purchase of one or more health insurance plans. such term shall not include a group health insurance plan (as defined in paragraph (5)(B)(ii)).

The term "self-insured sponsor" includes any entity which establishes or maintains a self-insured plan.

The term "state commissioner of insurance" includes a state superintendent of insurance.

Section 11009. Termination. (a) Provides that this title will not apply to a health insurance plan provided in a state on and after the time a state implements universal coverage pursuant to the provisions of this Act.

(b) Provides that, for self-insured plans sponsored by corporate alliance eligible sponsors, the provisions of this title will not apply as of the effective date of the sponsor's election to be a corporate alliance. For self-insured plans sponsored by a sponsor that is not such an eligible corporate alliance sponsor, the provisions of this title will not apply in a state on and after the time a state implements universal coverage pursuant to the provisions of this Act.